Medicaid Encounter Data

December 2001

Arthur A. Hayes, Jr., CPA, JD, CFE
Director

Ronald M. Paolini, CPA
Assistant Director

Jim Harrison, CMSW
In-Charge Auditor

Karen Degges
Tammy Farley
Jacqueline Laws
Staff Auditors

Amy Brack
Editor

Comptroller of the Treasury, Division of State Audit
1500 James K. Polk Building, Nashville, TN 37243-0264
(615) 401-7897

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STATE OF TENNESSEE
COMPTROLLER OF THE TREASURY
State Capitol
Nashville, Tennessee 37243-0260
(615) 741-2501

John G. Morgan
Comptroller

April 23, 2002

Members of the General Assembly
and
The Honorable Don Sundquist, Governor
State Capitol
Nashville, Tennessee 37243
and
Mr. Mark Reynolds, Director
TennCare Bureau
729 Church Street
Nashville, Tennessee 37247-6501

Ladies and Gentlemen:

Transmitted herewith are the results of our performance audit on the quality and completeness of Medicaid encounter data submitted to the State of Tennessee, Bureau of TennCare. This audit was performed in conjunction with The National State Auditors Association Joint Audit on Medicaid Managed Care.

Sincerely,

John G. Morgan
Comptroller of the Treasury

JGM
01/085

State of Tennessee

Audit Highlights

Comptroller of the Treasury Division of State Audit

Performance Audit
Medicaid Encounter Data
December 2001

AUDIT OBJECTIVES

This audit was conducted in conjunction with the National State Auditors Association Joint Audit on Medicaid Managed Care Encounter Data. The objectives of the audit were to determine the adequacy of the state's encounter data collection and editing processes; to evaluate how the state uses encounter data for management and operation of the TennCare Program; to determine the state's ability to use encounter data to detect program fraud and abuse; to verify the accuracy of the encounter data by examining provider records; and to make recommendations for improvement in the quality, completeness, and accuracy of encounter data.

CONCLUSIONS

Encounter Data Processes
The state has built a functional encounter data collection and verification system, which has, as a platform, the Medicaid Management Information System (MMIS) used for processing claims under the Medicaid Program. Using the TennCare reference files, the system is able to validate the individual fields that are entered on the claims such as the claim type, provider number, and date of service. The encounters are also compared to the TennCare history file to search for duplicate entries. Completed encounter data can be queried for various management and study purposes. However, there is no feasible method to verify that the monthly encounter data submissions by the MCOs and BHOs are the complete record of claims processed for that entire month.

Fraud and Abuse
The agencies within the state charged with the responsibility of working to prevent provider and recipient fraud and abuse are able to access encounter data to use it as a tool in their efforts. Because the encounters are not complete, there are limits on their ability to use the data.

Quality of Encounter Data
Based on our review, encounter data submitted to the state by providers through the contracting MCOs and BHOs was found, by and large, to be supported by the source medical charts. Of the data elements examined, 94.9% agreed to the medical charts.

Completeness of Encounter Data

Based on our review, not all required encounters are being submitted to the MCOs and BHOs, and therefore not all are being submitted to the state. We found that encounters for capitated services are the ones most likely to not be submitted. A capitated agreement is an arrangement between an MCO or BHO and a contracting provider in which the provider receives a set amount per patient per month, regardless of whether an enrollee receives a service. If a capitated recipient does receive a service, the MCO makes no additional payment. However, submission of encounters is still required for capitated services.

"Audit Highlights" is a summary of the report. To obtain the complete report which contains all findings, recommendations, and management comments, please contact

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INTRODUCTION

PURPOSE AND AUTHORITY OF THE AUDIT

This performance audit of the submission, accuracy, and use of Medicaid encounter data in managed care plans is part of the National State Auditors Association (NSAA) 2001 Joint Audit on Medicaid Managed Care. Each year, NSAA sponsors joint projects to improve audit efforts through the sharing of information and expertise and to give states access to a national audience for those issues that need to be addressed from a federal or national perspective. Three other states participated in this project. The results of all these audits will be compared and shared among participating states. New York, as the coordinating state, will prepare a comprehensive report presenting a summary of findings and recommendations of all participating states.

A planning session for the audit was held in New York on October 23-24, 2000. At that time, the objectives of the audit and a tentative timeline were developed. Attendees also heard from three nationally known experts on the importance of collecting and validating encounter data in a managed care plan.

In August 2001, a mid-point meeting was held in Albany, New York. At the meeting, attendees provided updates on the progress of their audits.

OBJECTIVES OF THE AUDIT

The objectives of the audit were

1. to determine the adequacy of the state's methods for assuring timeliness, accuracy, and completeness of encounter data;

2. to evaluate how the state uses encounter data for management and operation of the Medicaid (TennCare) program;

3. to evaluate the state's ability to use encounter data to detect and investigate fraud and abuse;

4. to independently verify the accuracy of encounters by comparison to records at the provider sites, on a sample basis; and

5. to make recommendations for improvement in the quality and accuracy of encounter data.

SCOPE AND METHODOLOGY OF THE AUDIT

The audit studied the collection, use, quality, and completeness of encounter data, focusing on the year 2000. The audit was conducted in accordance with generally accepted government auditing standards for performance audits in the United States of America. The methods included

1. interviews with TennCare Bureau staff responsible for encounter data,
2. interviews with state agencies responsible for fraud and abuse cases,
3. periodic meetings and conference calls with the other participating states,
4. review of federal regulations and other literature regarding encounter data requirements, and
5. verification of encounter data to source medical charts for a sample of providers.

BACKGROUND

In January 1994, Tennessee received federal approval to implement TennCare, which replaced most of the state's existing Medicaid Program. The Health Care Financing Administration (HCFA) granted a five-year demonstration project under Section 1115 of the Social Security Act. The TennCare waiver was unique in that it not only permitted enrollment of the existing Medicaid-eligible recipients, but also gave uninsured and uninsurable persons access to insurance. Long-term care and behavioral health services were not included in the waiver at this time.

Twelve managed care organizations (MCOs) were initially granted contracts to enroll eligible recipients and contract with medical providers to provide services to the recipients.

On July 1, 1995, Tennessee reached 90% of its enrollment cap and closed enrollment to uninsurable recipients. The suspension of uninsured enrollment was necessary because there must be capacity in the program to enroll Medicaid-eligible persons. Enrollment was reopened to uninsured children under 18 years of age on April 1, 1997.

On January 1, 1996, behavioral health services were included within the waiver, and two behavioral health organizations (BHOs) contracted with the state to form the TennCare Partners Program. In December 1998, HCFA approved a three-year waiver extension from January 1, 1999, to December 31, 2001. The state now has another waiver extension pending with HCFA.

On July 1, 1998, the state assumed financial responsibility for the cost of all behavioral health pharmacy services to TennCare enrollees in the TennCare Partners Program. Also, on July 1, 2001, the state assumed the pharmacy costs for dual-eligible recipients who are nursing home residents. Dual-eligible recipients are those who have Medicare as well as TennCare

coverage. About 90% of all nursing home residents are dual-eligible. Currently there are plans for the state to assume the costs of providing dental services in July 2002.

As of November 29, 2001, there were 1,471,081 recipients enrolled in the TennCare program. Recipients are eligible under the "Medicaid" category or are enrolled in the "Uninsured/uninsurable" category. Those in the latter category are subject to premium payments if their income is over 100 percent of the federal poverty level. Approximately 57% of the enrollees are in the Medicaid category, and 43% are uninsured/uninsurable. Of the 43% uninsured/uninsurable, about one-third are over 100 percent of the federal poverty level and are subject to premium payments. About 39% of the enrollees are children. (See Appendix 1 for TennCare enrollment by managed care organization.)

ENCOUNTER DATA PROCESS

Managed care and behavioral health organizations contracting with the state TennCare program are required to submit monthly reports of encounter data to the state.

Section 2-10.e. of the Contractor Risk Agreement between the state and the MCOs states:

> Individual encounter/claim data shall be reported in a standardized format as specified by TENNCARE and transmitted electronically to TENNCARE on a monthly basis by the 15th of each month. In the event a national standardized encounter reporting format is developed, the CONTRACTOR agrees to implement this format if directed to do so by TENNCARE. The minimum data elements required to be provided are identified in Attachment XII, Exhibit G of this Agreement.

Definition of Encounter

Based on interviews with TennCare, an encounter is defined as a claim. Reports of encounters produced by TennCare such as the sample encounters provided to auditors for this audit appear as detailed claims listings with fields added by the MCO or BHO during adjudication. Typically a provider will enter basic fields such as enrollee name, address, provider number, procedures, units, and diagnoses. Examples of fields that may be added by the MCO include amount paid, denial codes, and the MCO/BHO identification number. When a recipient receives a service at a provider site, the provider submits a claim for payment to the managed care organization in which that recipient is enrolled. The claim, which can be submitted electronically or in paper form, is then entered by the MCO/BHO into its claims processing system for adjudication. Once the claim passes the various system edits and audits of the MCO or BHO, a payment is sent to the provider with a remittance advice explaining the amount paid or lack of payment. Should the claim fail, a remittance advice is sent to the provider explaining the reason for the denial. If a recipient receives a service that is covered under a "capitated" arrangement between the MCO/BHO and the provider, then the provider will of course receive no payment. A capitation payment is a prospective payment method that pays

the provider of service a uniform amount for each person served, usually on a monthly basis. In instances where recipients included in a capitated plan receive a service, the provider is still required to submit a completed claim for encounter data purposes to the MCO/BHO. The MCOs and BHOs submit both paid and denied claims to the state as encounters.

After MCOs/BHOs receive encounters from their contracting providers and adjudicate those claims, claims will fall into one of three categories: paid, denied, or pending for additional information. Only claims that have reached the paid or denied status are submitted to the state as completed encounters. Claims in pending status are not submitted until they reach a paid or denied status.

Based on our discussions with the other states participating in this project, encounters appear to be defined in terms of claims.

Types of Formats

TennCare has five encounter data formats:

- the UB92, used for hospital, home health, hospice, and rural health services
- the HCFA 1500, for professional (physician), medical equipment, and transportation
- the Dental encounter (modified HCFA 1500)
- the Vision encounter (HCFA 1500)
- the Pharmacy encounter (state-specified format)

See Appendix 2 for a list of data elements required to be reported on encounters.

Submission of Encounter Data

The MCOs and BHOs are required per their contract with TennCare to submit encounter data to the TennCare Bureau by the 15th of each month. The submitted data is to include all processed claims for the prior month (regardless of the service period of the claim). The MCOs and BHOs are required to submit the encounter data by electronic transmission.

As an incentive to submit the data timely, 10% of the monthly payment made by the state to the MCOs and BHOs is routinely withheld at the beginning of the month, pending acceptance of the encounter data. The MCO or BHO receives 90% of its capitation on the first of the month, plus the released withhold from the prior month if it is in compliance with the requirements at that time. Therefore, in any given month, an MCO or BHO is at risk of having 10% of its capitation income withheld if it does not submit the encounters timely. The 10% withhold can be reduced to 5% for MCOs or BHOs that demonstrate consistent compliance with encounter data submission requirements. If an MCO or BHO remains out of compliance for six consecutive months, it is subject to a permanent monetary withhold. The state has in fact exercised the permanent withhold in a few cases.

The first step in TennCare's handling of monthly submissions is to determine that each MCO and BHO has submitted each of the five encounter data types, as applicable, by the 15th of the month. The BHOs will not have encounters for vision, dental, or pharmacy. Failure to submit all five types (if applicable) is considered noncompliance. If, however, an MCO has some difficulty with one set, the state can give the MCO an additional week or two to submit it while the other parts are being edited. In no case, however, would the extra time allowed extend into the next month.

After receipt, the data are then loaded to the TennCare system and subjected to a series of edits and audits. There are two cycles involved in the editing process. The first is called the "daily cycle," which performs most of the data validation. Examples of the daily cycle edits include, but are not limited to, recipient and provider eligibility, amount fields not numeric, diagnosis codes not valid, charges missing or totaled incorrectly, and valid dates of birth. There are several daily cycles run during the month. In December 2001, there were 49 daily cycles run for the MCO encounter data. Encounters that fail the daily cycle are sent back to the managed care organization for correction.

The next step in the editing sequence is called the "weekly cycle." The term originates from the old Medicaid system that ran this editing cycle once a week. Currently, this weekly cycle is actually run just once a month. The weekly cycle performs three functions. First, it reruns all of the edits and audits that were checked on the daily cycle. Second, the encounters are matched to the TennCare history file to check for duplicates. Finally, once that is completed, the encounters are added to the history file and are ready for production.

The encounters that are moved to production are considered completed and are then available for generating reports. Examples of reports that are generated from encounter data include

- number of emergency room visits (in order to track the use of hospital services);
- the Women's Health Report, produced annually, which includes the number of mammograms, number of pap smears, etc.;
- pediatric asthma inpatient admissions and ER visits; and
- the UT-Memphis Study on the Quality of Care Received by HIV and AIDS Patients in Tennessee.

The TennCare Program has developed an encounter data system that is able to collect, process, and edit the encounters timely. However, there is no way to assure that the encounters submitted by the MCOs and BHOs are complete. TennCare can determine if the number of encounters submitted in a particular month varies significantly from what has been reported in prior months. In those cases, TennCare personnel follow up with the MCO or BHO to determine if there are possible missing encounters. The state does not perform sample medical record reviews to corroborate encounters. To our knowledge, this audit is the first time that any such corroboration of encounters to source medical charts has been performed.

FRAUD AND ABUSE

Our review of the role of encounter data in fraud and abuse detection was limited to interviews of staff at the Tennessee Bureau of Investigation (TBI), the agency responsible for TennCare provider fraud and abuse; and the Program Integrity Unit at the Department of Health, which investigates TennCare recipient and provider fraud and also supports the TBI in its investigative efforts. The staff interviewed included the Special Agent In Charge of the Medicaid Fraud Control Unit at the TBI and the Director of the Department of Health Program Integrity Unit.

The TBI has 37 agents and support staff who work on TennCare provider fraud. Under its grant with the Centers for Medicare and Medicaid Services (formerly the Health Care Financing Administration), the TBI does not work recipient fraud and abuse cases. In addition, the Program Integrity Unit located within the Department of Health has a staff of 15 personnel who also work health care fraud cases. Currently, this unit is working all TennCare cases. The Program Integrity Unit is able to work recipient cases as well as provider cases. The two units meet often to coordinate their efforts and share resources and staff to work particular cases.

The TBI obtains the encounter data files from TennCare for use in its cases. Typically, after it makes a decision to open a case, the TBI will retrieve the encounter data for the provider or providers under review. The TBI has its own data processing personnel to perform this function. TBI's fraud investigations are typically started from referrals from TennCare or MCOs. Some cases are initiated by contacts from informants. Currently, the TBI is not reviewing encounter data to search for patterns that may yield a good case, but it plans to do so in the near future.

Since 1994, the TBI has continually improved its ability to access and use TennCare encounter data to assist it with fraud and abuse cases. At this time, the TBI is acquiring some personal computer applications which will improve its ability to query the data. Previously, the TBI had been using slower and more cumbersome main frame applications. The TBI indicated that the encounter data are good and have helped the TBI with its cases. However, the TBI has discovered during casework that encounter data are not complete concerning unenrolled providers. MCOs and BHOs must ensure that the providers in their network are properly licensed and enrolled on the TennCare system. There are times, however, when an MCO or BHO must use out-of-network providers to fill temporary gaps in their networks in order to ensure that recipients receive services promptly. Out-of-network providers are typically specialists who are not under contract with the MCO or BHO. Out-of-network providers may not always be credentialled and enrolled on the Medicaid system. Therefore, during the encounter data editing process, encounters for non-network providers may fail and not make it to production.

A second example of incomplete data is providers having multiple numbers. Not all of the numbers are included on the TennCare system, and thus some encounters could fail final edits due to lack of a valid provider number. Multiple numbers typically occur when a physician is in a group practice. Once MCOs and BHOs are notified of these failures, they are supposed to complete the credentialling process.

Continually exploring ways to improve the fraud detection process, the TBI holds monthly meetings to discuss fraud and abuse issues. Representatives of the MCOs, BHOs, and the Program Integrity Unit attend these meetings. It was noted that not all MCOs attend every month and that representatives of the TennCare Bureau do not attend. MCOs and BHOs have an incentive to detect fraud and abuse because they directly pay the price for invalid payments since they are paying for the services. One drawback in the program is that an MCO/BHO can only check its own encounter data. It does not have access to the encounters of other MCOs or the BHOs. Therefore, if an MCO or BHO is checking for patterns of overutilization by a provider, it may not have the total picture because that provider is likely providing services for one or more of the other MCOs or BHOs.

The most recent MCO contract amendment requires all MCOs to have active fraud and abuse units and requires them to submit plans for establishing and operating those units. However, according to the TBI, only one of the nine MCOs presently has an effective fraud and abuse unit.

ACCURACY AND COMPLETENESS OF ENCOUNTERS

To evaluate the accuracy (encounter information agrees with source documents) and completeness (encounter information contains all information included in the source documents) of encounters submitted by providers to the health plans and ultimately to the state, we selected a sample of encounters from the state for verification at provider sites.

Encounters were selected from September 2000 service dates. September 2000 was chosen because encounters for that service period would have enough time to be filed and to pass all system edits by June 2001. Eight providers were selected for detailed review:

- community mental health center (outpatient)
- primary care physician
- physician specialist
- acute care hospital (rural)
- acute care hospital (urban)
- inpatient psychiatric hospital
- community clinics (two providers)

We decided to limit our review to the above encounters, which represent the majority of the encounters submitted by the MCOs. Also, we did not review the pharmacy encounters at this time because during the period under review the state was moving a large part of the pharmacy program in house.

For each provider, we asked the TennCare Bureau to retrieve all reported encounters with service dates in September 2000 that had been moved to final production. A disk was provided that contained the requested encounters. In the remainder of this report, we will refer to this population of September 2000 encounters as the population data. We did not conduct testwork at

TennCare to assure that all encounters for the selected month for the selected providers were on the disk.

Our review was intended to determine the accuracy of certain fields reported on the encounters. We concentrated our review effort on the data fields that we believe to be important for the encounter data to be useful. Those fields included, but were not necessarily limited to, diagnosis codes, procedure codes, revenue codes (where applicable), units of service, and service dates. We did not attempt to review the accuracy of claim payments since that process is covered in our normal reviews and audits of the TennCare MCOs.

Our review was limited to examination of encounters at their origination (the medical charts of the provider). We did not attempt to judge the medical necessity of services, nor did we review the encounter data process at the MCOs.

Sample Selection

From the population data for each of the eight providers, we randomly selected subsamples of encounters for field review. Subsamples were necessary because the population data were very large, sometimes in the thousands. The subsamples were selected randomly using random number tables. We did not attempt to select statistical samples. This sample will be referred to as the primary sample in the remainder of this report. The primary sample was tested to determine how well the encounters were supported by documentation in the source medical charts at the provider sites.

In addition to the primary sample, we requested each of the providers selected for study to select at least five encounters (medical charts) with September 2000 service dates. The five selected by the provider were to be mutually exclusive from the primary sample. This second sample will be referred to as the secondary sample in the remainder of this report. The secondary sample was requested for one purpose: to test for completeness of the encounter submissions. The encounters selected by the provider should at least appear in the population data. When time permitted, we also verified the accuracy of the encounters for the secondary sample, although that was not its main purpose.

Results of the Chart Verification

In this section, the results of the medical chart reviews are presented, as well as the results of the secondary samples.

1. Community mental health center (outpatient)

Primary Sample

Community mental health centers contract with the Behavioral Health Organizations (BHOs) to provide mental health services for TennCare enrollees. All TennCare recipients are enrolled in one of the two BHOs.

A sample of 15 recipients was selected from the population data for this provider. If the recipients had more than one encounter, all encounters were chosen. For this provider type, we determined that the following data elements would be examined: service dates, primary and secondary diagnoses, and procedure codes. The total number of fields examined was 460. There were 18 fields in the medical records examined that did not agree with the state's encounter data. One encounter had an incorrect diagnosis code with the remaining fields matching the encounter data correctly. There was no supporting documentation in the recipient's file for six of the sample encounters. The error rate for this sample was 3.91%.

Secondary Sample

The community mental health provider selected ten charts for TennCare recipients who had any service provided in September 2000. This sample was chosen to be mutually exclusive of the primary sample.

For the 10 selected charts, a total of 19 encounters were found with September service dates. Of the 19 encounters, 4 did not appear in the population data. The chart did indicate that a valid service was provided. Further review indicated that the most likely reason for these missing encounters was that the provider was not enrolled on the TennCare system. Community mental health centers sometimes send their clients to other providers for special types of services that they cannot provide in house. The community mental health centers have been working with the BHOs to ensure that all providers are enrolled on the TennCare system. After discussing this matter with personnel at the mental heath center, it appears that some progress is being made on provider enrollments.

The secondary sample demonstrates that the state's encounter data are incomplete.

2. Physician (primary care)

Primary Sample

A sample of 19 encounters was selected from the population data for this provider. An on-site review of the medical charts was performed. For this provider type, we determined that the following data elements would be examined: service dates, diagnoses codes up to five occurrences, procedure code (first occurrence only), and the number of units and amount billed that correspond to the first procedure code. In the 130 data elements examined, ten errors were noted, all for diagnosis codes on the state's encounter data that did not appear on the medical records examined on-site. Further discussion with the provider indicated that those diagnosis

codes were likely put on the bill later, based on the notes in the medical record. It was not possible for us to validate those additional codes. The error rate for this sample was 7.7%.

Secondary Sample

The secondary sample selected by the provider was, at our request, all capitated services. Typically, a primary care provider will have some of his or her services under a capitated arrangement with one or more MCOs. For those services, the provider receives a set amount per enrolled patient per month, whether the recipient actually receives a service or not. Our review revealed that none of the capitated services selected by the provider appeared in the population data. This was not an unexpected finding. It has been generally suspected that providers do not always submit encounters for capitated services. Since capitated services do not generate a payment to the provider, submission of encounter data for capitated services is not a high priority. Based on the review of the charts, it appears that the recipients did receive proper services even though the encounters were not filed. We were able to conclude from discussions with the provider that the encounters were not submitted. Thus, we can conclude that the state's encounter data are not complete.

3. Physician (specialist)

Primary Sample

The specialist physician chosen for review had a total of 20 encounters in the population data. We decided to select all 20 of the encounters for review. For this provider type, we determined that the following data elements would be examined: service dates, primary diagnosis, secondary diagnosis, procedure codes, and units. The total number of fields examined was 105. No discrepancies were noted. Since all encounters for September 2000 were examined, there was no secondary sample for this provider. The error rate was zero.

4. Acute care hospital (rural)

Primary Sample

A sample of 15 inpatient and 15 outpatient encounters was selected from the population data for review at the hospital provider site.

For the 15 inpatient encounters for this provider, we tested the following data elements: date of service, length of stay, covered days, non-covered days, diagnosis codes (up to five), hospital procedure code, surgical procedure code (up to three), and the first revenue code and the units and amount billed that correspond to the revenue code. The total number of fields examined for the inpatient encounters was 216. There were nine errors noted. Three procedure codes were incorrect, five diagnosis codes were incorrect, and one revenue code was incorrect. The error rate for inpatient encounters is 4.2%.

For the 15 outpatient encounters for this provider, we tested the following data elements: dates of service, diagnosis (up to five occurrences), and the first four occurrences of revenue

codes and the units and amount billed that correspond to the revenue code. The total number of fields examined for the outpatient encounters was 178. There were nine errors noted. All errors were for the same encounter. The hospital was able to locate the medical record for this recipient, but the record did not document an encounter for that date of service. The error rate for outpatient encounters is 5.1%.

Secondary Sample

The provider randomly selected five encounters with September 2000 services. All five were outpatient encounters and were found in the population data. The data elements for these records were compared with the encounter data from TennCare. No discrepancies were noted.

5. Acute care hospital (urban)

Primary Sample

A sample of 30 encounters (15 inpatient and 15 outpatient) was selected from the population data for review at the provider site.

For the 15 inpatient encounters for this provider, we changed the fields to be tested from the first hospital provider. We tested the following data elements: dates of service, diagnosis (up to five occurrences), procedure codes (up to two occurrences), and the first six occurrences of revenue codes and the units and amount billed that correspond to each revenue code. The total number of fields examined for the inpatient encounters was 385. We found a total of 18 fields that did not agree with the state's encounter data. The 18 errors were as follows: 8 errors were in the unit field, 5 errors were in the revenue code field, and 5 errors were found in the amount billed. No discrepancies were found in the fields for primary diagnosis or procedure code. The error rate for this sample is 4.7%.

For the 15 outpatient encounters for this provider, we tested the following data elements: date of service, diagnosis (up to three), hospital procedure code, surgical procedure code, and the first five occurrences of revenue codes and the units and amount billed that correspond to each revenue code. The total number of fields examined for the outpatient encounters was 220. No discrepancies were noted.

Secondary Sample

The provider randomly selected five other encounters with September 2000 services. Two of the five were not found in the population data. The medical record contained documentation for the services provided with respect to these encounters. It is not known why these encounters were not reported to the state. This further supports our conclusion that the encounter data are not complete.

6. Inpatient psychiatric hospital

Primary Sample

A sample of 14 encounters was selected from the population data for review at the provider site. For this provider type, the following data elements were examined: dates of service, length of stay, covered days, non-covered days, primary diagnosis, and the first revenue code and the corresponding amount billed. The total number of fields examined was 184. The medical records at the facility accurately supported all encounter fields in the sample. This provider does not have outpatient services.

Secondary Sample

The provider also randomly selected five encounters with September 2000 service dates. All five of those encounters were found in the population data. No discrepancies were noted.

7. First community clinic

Primary Sample

A sample of 19 encounters was selected from the population data for review at this provider's site. For this provider type, the following data elements were examined: date of service, diagnosis codes (up to five), procedure code, and amount billed. The total number of fields examined was 119, and 15 errors were noted. The 15 errors were as follows: 2 dates of service, 5 diagnosis codes, one procedure code, and 7 amounts billed. The error rate for the primary sample for this provider was 12.6%.

Secondary Sample

The provider randomly selected five encounters with September 2000 services. Two of the five could not be found in the population data. It is possible that the missing encounters in the secondary sample were for capitated services. Ultimately, we could not determine why the two missing encounters were not reported to the state. This further supports the conclusion that the encounters are not complete.

8. Second community clinic

Primary Sample

A second community clinic was chosen for review. Both of the community clinics are similar provider types. A total of 19 encounters were selected from the population data for review at the provider site. For this provider type, the following data elements were examined: date of service, diagnosis codes (up to four), procedure code, units, and amount billed. The total number of fields examined was 125. There were 25 errors noted. The errors were as follows: 2 dates of service, 5 diagnosis codes, and 18 amounts billed. The error rate for the primary sample was 20%.

Secondary Sample

The provider selected five additional encounters with September 2000 service dates. None of the five encounters selected by the provider appeared in the population data. The five additional encounters (showing zero for amount paid) were capitated services and were not submitted, indicating that the state's encounter data are not complete. Based on the review of medical records for these encounters, it appears that the recipients received proper services.

CONCLUSIONS

1. The state has developed a functional encounter data system. The system checks for timely receipt, checks receipt of each of the required formats, performs accuracy validation, and checks for duplicates. There are procedures in place that ensure the encounter data are submitted timely by the MCOs, including withholding of payments to the contracting MCOs and BHOs. Payments are permanently withheld if MCOs do not correct encounter data deficiencies within six months of the month of submission. There is not a practical way to verify that monthly encounters submitted by the MCOs are a complete record of their monthly paid and denied claims. However, if a significant variation in the quantity of data received is noticed, the state follows up on potential problems with the submission. Once the encounters are moved to final production, they should be sufficient in quality to be used for various program and management purposes.

2. The state is able to access and use encounter data to assist with fraud and abuse cases. The state agencies charged with the responsibility of investigating program fraud and abuse indicate they can retrieve and use the encounter data but cannot be assured that they have all of the encounters associated with a particular provider or recipient fraud case. Unenrolled providers, including out-of-network providers, appear to be one area where the encounters are deficient. Another problem concerns group and individual provider numbers that are not cross-referenced as they previously were under the under the state's old Medicaid system.

3. Submitted encounters are reasonably accurate. Our review indicated that the encounters submitted to the state for services rendered to TennCare recipients are accurate representations of the services actually provided. The encounters were good matches to the source medical charts. In most cases, fields that did not match were in the latter part of the record, such as third and fourth diagnosis codes, or some of the later revenue codes on the inpatient record. In a few cases, we found that medical charts contained additional diagnosis codes beyond the second or third that were not entered on the encounter. The average matching percentage for the fields on the encounters we tested was 95.1%. A summary of the data elements that were verified on each encounter in the primary sample for the selected providers is on the following page.

4. Not all encounters are being submitted. Our review revealed that not all encounters are reported to the state. Encounters representing capitated services frequently are not being submitted to the MCOs or BHOs by the providers. Since there is no additional payment made for a capitated service, there is a lack of incentive for the provider to submit capitated encounters. As noted previously, we did not follow the process through the MCO. We noted that at least one other reason for failed encounters is rejection due to an unenrolled provider. Since the encounter data are not complete, their usefulness is compromised for certain purposes. For example, when the state's consultants perform the annual actuarial study for determining appropriate TennCare payment rates, they must make allowances and adjustments for missing encounters because of the missing capitated encounters. For other purposes, the encounters are useful. For example, when determining the number of hospital admissions per year, the data appear to be complete since hospital inpatient encounters are not capitated.

Summary of Validation of Encounter Data

Provider Type	Total Data Element Fields Examined	Total Errors	Error Rate
Community Mental Health Center	460	18	3.9%
Primary Care Physician	130	10	7.7%
Physician Specialist	105	0	0.0%
Urban Hospital, Inpatient	385	18	4.7%
Urban Hospital, Outpatient	220	0	0.0%
Rural Hospital, Inpatient	216	9	4.2%
Rural Hospital, Outpatient	178	9	5.1%
Inpatient Psychiatric Hospital	184	0	0.0%
First Community Clinic	119	15	12.6%
Second Community Clinic	125	25	20.0%
TOTAL	2,122	104	
AVERAGE ERROR RATE			4.9%

RECOMMENDATIONS

1. The TennCare Bureau and the MCOs and BHOs should coordinate their efforts to assure that all providers, both in and out of network, are credentialled and enrolled in the state system before claims and encounters are processed. This would decrease the rejection of encounter data by the state and decrease the number of times the MCOs have to submit corrected encounter data. Also, the state should require the managed care organizations to implement policies for capitated providers to assure that capitated encounters are filed. Such policies could include periodic on-site reviews and monetary sanctions for failure to submit all encounters.

2. In order to ensure the ongoing integrity of the encounter data, the state should, on a sample basis, perform medical record reviews at selected provider sites. The state could use the External Quality Review Organization (EQRO) or other contractual arrangements to perform this function. To our knowledge, aside from this review, validation of TennCare encounters to medical records has never been done.

MANAGEMENT COMMENTS

TennCare edits the provider information reported against the MCOs' provider cross-reference file submitted on a monthly basis. Encounter files that exceed the 2% error ratio for providers not on the MCOs' provider cross-reference are rejected. The MCOs and BHOs should edit the encounter data prior to submission to ensure all providers have been submitted to TennCare.

The Office of Contract Compliance should amend the contract risk agreement to require all capitated services are submitted electronically to TennCare on a monthly basis.

Audits should be performed on a regular basis by the Quality Oversight unit to ensure that TennCare receives all encounters from the MCOs and BHOs.

APPENDIX 1

TENNCARE ENROLLMENT BY MANAGED CARE ORGANIZATION
As of November 29, 2001

Managed Care Organization	West Tennessee	Middle Tennessee	East Tennessee	TOTAL
OmniCare	79,869	-	-	79,869
BlueCare	-	-	287,954	287,954
TennCare Select	156,885	105,244	89,022	351,151
Better Health Plans	40,519	-	-	40,519
John Deere	-	-	70,102	70,102
Memphis Managed Care Company, Inc.	169,163	-	-	169,163
Universal	-	141,674	-	141,674
Xantus	-	178,908	-	178,908
Preferred Health Partnership	-	-	118,001	118,001
Vanderbilt Health Plans, Inc.	-	33,740	-	33,740
TOTAL	446,436	459,566	565,079	1,471,081

Source: TennCare Web Site: www.state.tn.us/tenncare *updated 12/17/01*

Note: Current information on the managed care organizations and enrollment can be obtained at the TennCare Web site: www.state.tn.us/tenncare.

APPENDIX 2

The following are the data elements common to all encounters and those that are specific to certain provider types.

INDIVIDUAL ENCOUNTER REPORTING – REQUIRED DATA ELEMENTS

Common Data Elements

Claim type
Provider number
Provider type
Servicing provider
Primary care provider number
Enrollee number
Procedure code
Claim and Procedure modifier
Type of service
Number of units
Date(s) of service
Billed charges
Third-party liability
Allowed amount
Amount paid
Primary diagnosis
Secondary diagnosis
Diagnoses 3 through 5
Provider type
Provider specialty

Professional Specific

Referring provider number
Anesthesia units
Place of treatment

Community Health Clinic Specific

Drug codes
Drug quantity
Place of treatment
Drug day supply
Drug charges
Referring provider number

Ambulance Specific

Emergency date
Destination
Referring provider number

Dental Specific

Tooth number
Emergency indicator
Tooth surface

Hospital Specific

Attending physician
Discharge date
Covered days
UB 92 revenue codes
Surgical procedures
Admitting physician
Admit date
Non-covered days
Revenue charges
Per-diem

Bill type	DRG data
Admitting diagnosis	Discharge diagnosis

Pharmacy Specific

Prescribing physician number	Prescription number
Refill number	Days supply
Nursing home indicator	Unit dose indicator

Hospice Specific

Certification date	Attending physician
Admitting physician	Date care begins
Treatment place	Covered days

Source: Attachment XII, Exhibit G - Individual Encounter Reporting/Required Data Elements of the Contractor Risk Agreement between TennCare and the MCOs.